JANUARY 2019

GRS INSIGHT

IN THIS ISSUE

IRS Issues Private Letter Ruling on Code Sections 415 and 414(h)(2) Requirements

In late November 2018, the Internal Revenue Service (IRS) issued a private letter ruling addressing, among other things, the: 1) application of the limits under Section 415 of the Internal Revenue Code (the Code) when a plan has defined benefit and defined contribution features; and 2) requirements for valid pick-up elections under Code Section 414(h)(2).[1] These portions of the ruling are described in more detail below.

Facts

Historically, a State sponsored Plan 1 and Plan 2, each of which consisted of a defined benefit pension benefit funded by employer contributions, and a defined contribution benefit paid from an annuity savings account (ASA) and funded by employee contributions. The State treated each of Plan 1 and Plan 2, including their ASA portions, as single defined benefit plan structures. Thus, Plans 1 and 2 tested benefits payable under the ASAs based on the rules applicable to governmental defined benefit plans under Code Section 415(b).

Prior to a "Transition Date," the payment of the lifetime annuity from each ASA was guaranteed by the applicable Plan, and an investment fund with a guaranteed rate of return was available (the Guaranteed Fund). However, beginning on the Transition Date, the State began outsourcing the annuity payments of the ASAs to a third-party annuity provider, eliminating internally guaranteed lifetime annuity payments from the ASAs.

The State later added Plan 3 as an alternative to Plan 1 for certain employees. Plan 3 functions as a defined contribution plan with employer contributions going to an ASA rather than to fund a defined benefit pension benefit. While the State initially treated Plan 3 as a component of Plan 1 rather than a separate defined contribution plan, Plan 3 is now treated as a separate plan. The State also established Plan 4 as an alternative to Plan 2. Plan 4 is a defined contribution plan that operates similarly to Plan 3.

As of the Transition Date, Plan 1 was split to create two plans: Plan 5, which includes the Plan 1 defined benefit structure, and Plan 6, which includes the Plan 1 ASAs. Further, Plan 2 was split to create three plans: Plan 7 and Plan 8, which are two Plan 2 defined benefit structures, and Plan 9, which includes the

[1] See Priv. Ltr. Rul. 201848011 (Nov. 30, 2018).

Plan 2 ASAs. Plan 3 and Plan 4 remain separate plans.

For all plans, the mandatory employee contribution rate is 3% of compensation. State law authorizes the State to pick-up and pay all or a portion of a member's contribution under Code Section 414(h)(2), and schools or political subdivisions may choose whether or not to pick up contributions.

Rulings Requested

The State requested the following rulings with respect to Code Sections 415 and 414(h)(2):

1. As of the Transition Date, for any member of Plan 6, Plan 3, Plan 9, or Plan 4 who has not yet commenced receipt of benefit payments from his or her ASA account, the State will convert the member's ASA balance to an annual benefit (under Code Section 415(b)(2)) and test that annual benefit under the Code Section 415(b) limit, as applicable to governmental plans, and after the Transition Date all contributions to the member's ASA will be tested under Code Section 415(c).
2. Mandatory employee contributions under Plan 6, Plan 3, Plan 9, and Plan 4 will be treated as picked-up contributions under Code Section 414(h)(2).

IRS Rulings

The IRS approved the State's requested application of Code Section 415. The IRS looked to the elimination of the Guaranteed Fund and guaranteed lifetime annuity payments from the ASAs as of the Transition Date as a defining point. For any member of Plan 1, Plan 2, Plan 3 or Plan 4 who had not commenced receipt of benefit payments from their ASA account as of the Transition Date, the State was required to convert that member's ASA balance to an annual benefit and test that annual benefit under the Code Section 415(b) limit. As of the Transition Date, Plan 3 and Plan 4, and the ASA accounts formerly under Plan 1 and Plan 2 (i.e., new Plan 6 and Plan 9) were separate defined contribution plans. Therefore, after the Transition Date, Code Section 415(c) would apply to all contributions to the member's ASA for any member of Plan 6, Plan 3, Plan 9, or Plan 4.

The IRS also granted the State's request in connection with the picked-up contributions. The State represented in its submission that formal action was taken specifying that the mandatory employee contributions will be paid by the employer in lieu of employee contributions and was evidenced by contemporaneous written documentation via either statute or resolution by the applicable legislative body. In addition, although a member may choose whether to be in Plans 5 and 6 or Plan 3, or whether to be in Plans 8 and 9 or Plan 4, no cash or deferred election arises from this election (i.e., the member cannot choose between receiving amounts directly or having them paid to the Plan), because the State represents that the mandatory employee contribution to each of the Plans is 3% of the employee's compensation. Therefore, the mandatory employee contributions under Plans 6, 3, 9, and 4 satisfy the conditions to be treated as picked-up by the employer under Code Section 414(h)(2).

Note that private letter rulings are directed only to the taxpayers requesting them and may not be used or cited as precedent.

Pension Plans Legislative Update

Retirement plans could see an uptick in applicable legislative activity in the next couple of years, as Rep. Richard Neal (D-Mass.), the new Chairman of the House Ways and Means Committee for the 116th Congress, has historically shown interest in retirement policy.

Specifically, Mr. Neal's prior history related to the: 1) sponsorship of legislation to ensure that every employee has access to an employer-provided retirement plan; 2) willingness to work on bipartisan proposals (including supporting the Retirement Enhancement and Savings Act); and 3) opposition to attempts to reduce the tax incentive for retirement savings, provide indications that he will likely use his chairmanship to focus on retirement legislation.

Further, on December 19, 2018, the Retirement Security and Savings Act was introduced which contains numerous provisions directed at retirement savings. The bill includes provisions to: amend the required minimum distribution rules; allow indirect rollovers to inherited IRAs by nonspouse beneficiaries; and expand the self-correction program under the Employee Plans Compliance Resolution System. With years of pent-up

demand, retirement policy is likely to be considered in the 116th Congress.

Employee Plans Compliance Resolution System Update

The Internal Revenue Service (IRS) has issued an update to the Employee Plans Compliance Resolution System (EPCRS) under Revenue Procedure 2018-52, which supersedes Revenue Procedure 2016-51. EPCRS provides the procedures by which plan sponsors can correct certain operational and document errors that would otherwise affect the tax-qualified status of their retirement plan, and includes three correction programs: the Self-Correction Program (SCP), the Voluntary Correction Program (VCP), and the Audit Closing Agreement Program (Audit CAP). Corrections under VCP require a written request to the IRS for approval of the correction method, while Audit CAP is available when an IRS agent finds errors during an audit of the plan.

The new Revenue Procedure makes limited changes to EPCRS, with the most significant change affecting the submission requirements for VCP applications. Specifically, beginning April 1, 2019, VCP applications (along with the applicable user fee), must be submitted electronically through the www.pay.gov website. For the transition period between January 1, 2019 and March 31, 2019, submissions via the website are optional.

In addition, Revenue Procedure 2018-52 provides some procedural clarifications. Specifically, if the IRS agrees with the proposed correction method, the IRS may issue a compliance statement without first contacting the applicant or authorized representative. Further, the IRS reserves the right not to issue a compliance statement for a VCP submission and to set forth the circumstances in which the user fee will not be refunded.

Non-VCP correction submissions for 457(b) plans must also be filed electronically. However, unlike a VCP, there is no upfront fee requirement (i.e., no fee is due on filing). The Revenue Procedure also provides additional clarifications on corrections for 403(b) plans, and included Audit CAP sanctions in the amounts to be paid electronically.

Brief Summary of New 403(b) Plan Relief

The IRS recently issued transition relief relating to the "once-in-always-in" (OIAI) rule for Section 403(b) plans. This relief was requested by commenters who stated that many employers were not aware of this condition in connection with the part-time exclusion.[2]

Under the general rule for non-church Section 403(b) plans, all employees of an employer generally must be permitted to make elective deferrals if any employee of the employer is permitted to make such deferrals. However, this rule is subject to certain exceptions, including the permitted exclusion of part-time employees who normally work less than 20 hours per week.

The part-time exclusion has three parts, permitting a plan to prohibit a part-time employee from making elective deferrals:

1. During the employee's first year of employment, if the employer reasonably expects the employee to work fewer than 1,000 hours during that year (the first-year condition).
2. In a later exclusion year:
    a. if the employee actually worked fewer than 1,000 hours in the preceding 12-month period (the preceding-year condition); and
    b. only if the employee meets the applicable exclusion condition for each year of employment (the OIAI condition) – i.e., once an employee is eligible to make elective deferrals, the employee may not again be excluded from making elective deferrals in any subsequent year solely due to part-time status.

The guidance is limited to relief for the failure to properly implement the OIAI condition solely for taxable years beginning after December 31, 2008 through the end of the last exclusion year applicable to the employee that ends before December 31, 2019. No relief is provided for the incorrect application of the other part-time exclusion conditions (i.e., the first-year condition; the preceding-year condition; and the requirement to uniformly administer these conditions).

[2] See Notice 2018-95 (Dec. 4, 2018).

In addition, the Notice provides a fresh-start opportunity whereby a plan will not be treated as failing to follow the part-time exclusion rules if: 1) the OIAI condition is properly applied as if the OIAI condition first became effective January 1, 2018; and 2) the plan was operated during the relief period either in compliance with the OIAI condition or pursuant to the relief provided under the Notice.

Health Litigation Update: *Texas v. United States*

On December 14, 2018, a federal district court judge ruled that the Affordable Care Act's (ACA) individual mandate is unconstitutional, and that the individual mandate was not severable from the remainder of the ACA, rendering the entire statute invalid. As of December 30, 2018, the judge has stayed his opinion pending appeal, with the result being that the ACA remains in force for now even though the law's eventual fate remains uncertain.

In February 2018, Texas (joined by several other states), sued the Administration, claiming that that the ACA's individual mandate, as amended by the Tax Cuts and Jobs Act of 2017, is unconstitutional and, therefore, that the rest of the law is invalid as well. The case is *Texas v. United States*, with district court litigation taking place before Judge Reed O'Connor in the Northern District of Texas. An appeal has been filed with the Court of Appeals for the Fifth Circuit.

Texas is arguing that, in *NFIB v. Sebelius*, the Supreme Court upheld the individual mandate as a tax and, as of January 1, 2019, the individual mandate is no longer a lawful tax because it does not raise any revenue. Since both Congress and the Supreme Court originally viewed the mandate as "essential" to the operation of the ACA, the ***entire*** law is thus unlawful and must be invalidated, with its operation enjoined. The litigation has generated a great deal of controversy, with the Department of Justice (DOJ) actually siding with Texas (though the DOJ has asked that the entire ACA not be invalidated) and 16 intervener states, led by California, intervening to defend the law.

In a victory for Texas, in his 55-page opinion and order, Judge O'Connor held that the zeroed-out individual mandate can no longer be construed as a lawful tax and that the rest of the ACA is, therefore, inseverable and invalid. Released the day before the close of the ACA's annual individual market open enrollment period, his decision created immediate confusion: Texas had requested a preliminary injunction, but Judge O'Connor issued a partial declaratory judgment (while reserving a number of related issues for further review) without actually ordering the Administration to cease the operation of the ACA *or* ordering a stay of his judgment.

To prevent disruption, the Centers for Medicare and Medicaid Services (CMS), the agency charged with implementing the most immediately implicated aspects of the ACA, quickly announced it would continue implementing the law while any appeal was pending. Furthermore, the litigants moved to allay confusion, with California immediately asking Judge O'Connor to clarify his order by issuing a stay and allowing the issue of the ACA's constitutionality to proceed to an immediate appeal.

On December 30, 2018, Judge O'Connor agreed to this approach in a 30-page order granting a stay and partial final judgment. The Judge reiterated some of his reasons for finding the ACA invalid, but nonetheless clarified that he would not enjoin the Administration from implementing the law while the appeal was pending. On January 3, 2019, California filed its notice of appeal. Furthermore, the House of Representatives, with its newly elected Democratic majority, voted to intervene to defend the ACA on the same date.

As a result, despite the massive controversy and media-attention garnered by Judge O'Connor's decision, the ACA remains in place for now. Even an expedited appeal will take months, with a further appeal to the Supreme Court likely to follow, and a final decision unlikely before Spring 2020. The final result remains uncertain: many legal commentators have been critical of Texas' arguments, particularly the notion that the entire ACA should be stricken down if the individual mandate is held unconstitutional; however, the plaintiffs have already convinced one court that the ACA is invalid. Since both the Fifth Circuit and Supreme Court have conservative-leaning majorities, there is a possibility that Judge O'Connor's opinion will be upheld in whole or in part.

The stay potentially places another case concerning the constitutionality of the ACA on hold. In September 2018, Maryland filed suit against the Administration in the District of Maryland (*Maryland v. United States*) requesting the Court to issue a declaratory judgment finding the ACA constitutional. While litigation in that case has been ongoing, with a hearing on the Administration's motion to dismiss held on December 19, 2018, and in a request for briefing issued on January 3, 2019, the Court signaled that it was considering staying the Maryland litigation pending *Texas'* appeal in the Fifth Circuit.

The possibility of another government shutdown risks delaying resolution and creating procedural difficulties. During the most recent government shutdown, the DOJ was unfunded and had been requesting stays in cases in which it had an interest. However, the Court in the Maryland litigation announced that it would not issue a shutdown-based stay in its January 3, 2019 order.

Tri-Agency Issues Proposed Guidance That Expands the Use of HRAs

On October 23, 2018, the Departments of Treasury, Labor, and Health and Human Services (the Departments) issued long-awaited proposed regulations that allow employers to offer health reimbursement accounts (HRA) that employees can use to pay for premiums for individual health insurance premiums and allow employers to offer HRAs that are excepted benefits (the Proposed Regulations). Furthermore, on November 19, 2018, the IRS issued follow-up Notice 2018-88 (the Notice). The Proposed Regulations generally apply beginning January 1, 2020, and entities may not rely on the Proposed Regulations or the Notice. Therefore, until final regulations are issued and effective, employers may not offer either of these new HRAs. Comments were due on the Proposed Regulations and Notice at the end of December and final regulations are expected in Spring 2019.

Background

Under current guidance, an HRA for active employees must be "integrated" with another group health plan to satisfy the Affordable Care Act's (ACA) market reform requirements that a plan cannot place annual dollar limits on essential health benefits and must provide certain preventive services without cost-sharing.

New Integration Rules

The Proposed Regulations create a new HRA, an individual coverage HRA (ICHRA), that is "integrated" with individual health insurance coverage. There are five requirements that an ICHRA must meet, described below:

1. **Enrollment in individual market health insurance coverage**

   To be integrated, any participant and dependent who can receive reimbursements from the ICHRA must be enrolled in individual market health insurance coverage for each month that they are covered by the ICHRA. The ICHRA must follow reasonable procedures to verify that all participants and dependents are enrolled in individual health insurance coverage during the plan year, including each time an expense is reimbursed.

2. **Prohibition against offering both an ICHRA and a "traditional group health plan" to the same class of employees**

   In general, an employer may not offer an ICHRA to a class of employees if the employer offers a "traditional group health plan" (a group health plan except an account-based health plan or a plan that consists solely of excepted benefits) to the same class of employees.

   If the employer offers an ICHRA to an employee in a class, it must offer the ICHRA on the same terms to all employees in that class. These classes are:

   - Full-time employees;
   - Part-time employees;
   - Seasonal employees;
   - Employees in a unit covered by a collective bargaining agreement;
   - Employees in a waiting period;
   - Employees who under age 25 at the beginning of the plan year;
   - Foreign employees who work abroad; and
   - Employees who work in the same rating area.

3. **Same terms requirement**

   Employers that offer an ICHRA to a class of employees generally must offer the ICHRA on the same terms and conditions to all employees within the same class. There are three exceptions to this rule:

   - An employer can increase the amount available under the ICHRA based on a participant's age. The Notice provides that the IRS anticipates issuing guidance that would allow an employer to vary dollar amounts across classes based on age if certain requirements are met without violating the Code Section 105(h) nondiscrimination rules.
   - An employer can increase the amount available under the ICHRA based on the number of the participant's dependents covered under the ICHRA.
   - An employer can offer the ICHRA to some, but not all, former employees within a class.

4. **Opt-out requirement**

   The ICHRA must allow participants to opt-out of and waive future reimbursements at least annually.

5. **Notice requirement**

   An ICHRA is required to provide a written notice to eligible employees at least 90 days before the beginning of each plan year that their participation will make them ineligible for a premium tax credit (PTC). The notice must include detailed information.

New Excepted Benefit HRA

The Proposed Regulations created a new HIPAA excepted benefit category to describe a stand-alone HRA (EBHRA). There are five requirements that an EBHRA must meet, which include:

1. The employer must offer other, non-account based, medical coverage to employees that is not an excepted benefit (e.g., not dental- or vision-only).
2. The amount of new employer contributions each year cannot exceed $1,800 (indexed).
3. The EBHRA can reimburse medical expenses and premiums/contributions for COBRA, excepted benefit medical coverage, or short-term limited duration insurance, but cannot reimburse premiums or contributions for other medical coverage.
4. The EBHRA must be made available on a uniform basis to all similarly situated employees, as defined in the HIPAA nondiscrimination regulations (*i.e.*, groups that are based on a bona fide employment-based classification, such as full-time, part-time, occupation, collectively bargained employees, geographic distinctions, length of service, date of hire).
5. An employer is not permitted to offer both an ICHRA and an EBHRA to the same group of employees.

Premium Tax Credit and Employer Mandate

An employee and dependents who can receive reimbursements from the ICHRA are ineligible for a PTC for any month in which he/she is enrolled in an ICHRA. Also, an employee (and a dependent who can receive reimbursements from the ICHRA) who is offered, but opts out of, an ICHRA is ineligible for a PTC for any month the ICHRA is affordable and provides minimum value.

An employer can satisfy the employer mandate requirements by using an ICHRA. There is no minimum dollar amount available under the ICHRA to satisfy the 4980H(a) requirements. However, to satisfy the 4980H (b) requirements, the ICHRA must be affordable and provide minimum value.

In general, an ICHRA is considered affordable for a month if the amount the individual would pay for the monthly premium for the lowest cost self-only silver plan available to the employee through the exchange for the rating area in which the employee resides, taking into account the amounts available under the ICHRA, is 1/12 of 9.5% (indexed) or less of the employee's household income. The Notice proposes safe harbors an employer can use to determine affordability for employer mandate purposes.

An ICHRA that is affordable will be deemed to provide minimum value.

About GRS

GRS is a national actuarial and benefits consulting firm. We help our clients develop and maintain fiscally sustainable benefit programs that preserve financial security for millions of Americans. Our reputation for providing independent advice and quality consulting services has remained unmatched for more than 80 years. To locate a GRS office, visit our website at: www.grsconsulting.com.